OFFICE OF THE CHILD ADVOCATE
REPORT

JUVENILE DETENTION CENTER INVESTIGATION
An Examination of Conditions of Care
For Youth with Mental Health Needs

Executive Summary

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Statement of the Problem

In New Jersey, county juvenile detention facilities are often used to confine youth with serious mental health needs. These youth are frequently held in detention centers due to the paucity of less restrictive placement options that would allow them to remain with their families or in their communities, where appropriate, and have access to care to address their identified needs. Detention centers are generally not equipped to identify youth with mental illness, to assess their condition or to provide them with necessary services to assure their stability and support their mental health while detained. Currently, there are few specific statewide standards to meaningfully address the mental health needs of detained youth; service provision is largely subject to the discretion of county administrators, the individual philosophy of detention directors, and resources available in that particular county. While we can readily accept, and expect, that the physical health of detained youth should be adequately addressed in a timely manner, many youth languish and decompensate in juvenile detention facilities across the State as their mental health needs go unmet while awaiting an appropriate placement.

On October 14, 2003, the Office of the Child Advocate (hereinafter "OCA") announced an investigation into the condition of care for youth in the 17 county detention centers, including overcrowding, access to mental and behavioral health services and the overall quality of services. The OCA conducted announced and unannounced site visits to each center across the State. The Office of the Child Advocate embarked upon this investigation to determine the extent of this problem and to make recommendations for meaningful reform.

This report memorializes the OCA's findings and recommendations regarding the confinement of mentally ill youth in New Jersey's 17 juvenile detention centers and the unmet needs of those youth. This report consists of four sections: (1) Introduction, which summarizes and describes the initiation, scope and framework of the investigation; (2) Investigation Findings; (3) Encouraging Developments, which discusses efforts currently underway that may impact mentally ill detained youth; and (4) Recommendations, which call for critical, immediate corrective action from the New Jersey Juvenile Justice Commission (hereinafter "JJC") and the New Jersey Department of Human Services (hereinafter "DHS").

A. The Scope of the OCA Investigation

The OCA's investigation included an examination of the following documents, produced by the JJC:

- Accounting of funds granted to the county Youth Service Commissions (hereinafter "YSCs") and the corresponding project descriptions;

- Monthly and yearly census data from each county detention center for 2001, 2002 and 2003;
- Correspondence between the Union County Juvenile Detention Center and the JJC from January 6, 1998 to December 3, 2003;
- Suicide Critical Incident reports received by the JJC as required by *N.J.A.C.* 13:92-7.6(b).

We also reviewed the following documents produced by the New Jersey Department of Human Services ("DHS"):

- Every Institutional Abuse Investigation Unit referral report from all 17 county juvenile detention centers from January 1, 2003 to October 15, 2004;

The OCA also conducted two assessments. During tours of all county juvenile detention centers conducted during the Spring of 2004, the OCA staff administered questionnaires to facility administrators from each county detention center, who provided the OCA with the following documents:

- Entries for the most recent 12 months from the Log for the Temporary Restriction of Juveniles required by N.J.A.C. 13:92-6.5;
- Entries for the last 12 months from the Mechanical Restraint Log required by N.J.A.C. 13:92-6.6;
- Any suicide prevention policies and/or procedures;
- Any suicide screening and/or assessment instruments;
- Any mental health screening and/or assessment instruments;
- Reports of medical costs incurred by all facilities in 2003;
- Internal critical incident reports from a limited number of county detention centers; and
- Weekly census data from each detention center from April 2004 to present;

A second assessment, conducted at five detention centers, evaluated the average time youth waited in detention before being transferred to a DHS child welfare or mental health treatment placement between April 1, 2004 and June 30, 2004. The OCA selected the participating counties after the initial round of surveys indicated that the facilities in these five counties had experienced the most recent overcrowding.

B. Summary of Findings

Twenty-one percent (21%) of all youth committed to the JJC have a serious emotional disorder, which is consistent with the over-representation of mentally ill children in detention nationally. With over 11,000 new youth admissions to the 17 county detention centers annually, and 935 youth, on average, in detention centers daily, we estimate that 200 youth experiencing serious mental health disorders are in detention in New Jersey on any given day.

The prevalence of serious mental health disorders among New Jersey's detained youth is further illustrated by the number of youth in need of psychotropic medication. Ten administrators reported that between ten and twenty-five percent (10-25%) of youth housed in their facilities were on psychotropic medication. Three administrators estimated that, on average, one-third of their facilities' residents were taking psychotropic medications. One administrator reported that between forty percent (40%) and fifty percent (50%) of residents were taking psychotropic medication.

Most startling, we learned of over 90 suicide threats or attempts in New Jersey juvenile detention centers from January 1, 2004 through August 30, 2004, a telling indicator of severe mental health distress among youth.

Our investigation confirmed that:

- detention centers in New Jersey are commonly overcrowded;
- youth with mental and behavioral health issues remain in detention for extensive periods of time in violation of the law;
- detention centers are grossly ill-equipped to care for children with serious mental health disorders;

Our findings, in summary, are:

(1) <u>In direct violation of the law, many detention centers have been required to house more youth than they are designed to hold</u>.

Despite the fact that New Jersey's Code of Juvenile Justice specifically prohibits the placement of any juvenile in a county detention center that has reached its maximum population capacity, overcrowding is a perennial problem for many juvenile detention centers. Five counties reported average daily populations for 2003 that exceeded the rated capacities of their facilities. Eleven detention centers reported they had confined more children on a given day than they were rated to hold during the past year.

Although children should only be detained in limited instances to promote public safety, youth with low-level offenses, including disorderly persons offenses, and no history of flight or dangerousness, are detained in New Jersey because alternative placements and services are scarce. The primary reason many of these youth are in detention is because the county detention center, unlike the schoolhouse, is the only place that cannot say no. Judges often find themselves confronted with a child who they deem to be appropriate for a community or non-secure detention alternative, only to find that no such alternative exists, particularly for children with acute mental health needs or children without families.

(2) <u>In direct violation of the law, youth are regularly held in detention centers, for extended periods of time, awaiting transfer to non-secure residential programs.</u>

Twenty-five percent (25%) of youth in detention throughout New Jersey were just awaiting a DHS placement, post-adjudication, in the Spring of 2004. Despite being found appropriate for less restrictive DHS/DYFS residential and community-based services, many youth are illegally confined to detention for extended periods of time. Juvenile detention is designed to be neither long term nor a placement for children with serious emotional disturbance or behavioral health needs. Nonetheless, many youth languish in confinement, with needs grossly unmet.

The continued confinement of a youth following disposition to a DHS child welfare or mental health placement is a plain violation of the law. *N.J.S.A.* 2A:4A-38(1) directs that "when a juvenile has been adjudicated delinquent and is awaiting transfer to a dispositional alternative that does not involve a secure residential or out-of-home placement and continued detention is necessary, the juvenile shall be transferred to a non-secure facility." This provision of the law, not unlike the prohibition against admitting a child to an over-capacity facility, is generally respected in the breach.

Detained youth waiting for a child welfare or mental health placement through DHS are confined, on average, 59 days in county detention centers. They are held even longer than youth sentenced to secure confinement, who are detained a combined average of 54 days in total, nearly a week less than youth headed to a child welfare or mental health placement through DHS (Figure 2). The cruel irony is that youth ultimately deemed by the court appropriate for non-secure child welfare or mental health placements through DHS are confined longer in county detention centers than the most acutely delinquent youth sentenced to a term in secure lock-up.

Although youth wait 59 days on average for a DHS placement, twenty-five percent (25%) of youth headed to DHS placements wait a combined average of 135 days in juvenile detention from admission to placement. For youth with acute mental and behavioral health needs, this equates to over four months of confinement without treatment and services. Despite being found appropriate for less restrictive residential and community-based services, many youth are confined to detention centers, the most restrictive placement available by law, an environment that is not designed or intended to offer long-term mental health treatment services.

Our review of detention center records revealed many incidents in which young people displaying symptoms of serious mental health disorder were involved in dangerous interactions with staff or other youth, several of which are excerpted below.

- In a period of fewer than eight weeks, from June 9, 2004, to July 24, 2004, one resident with acute mental health issues who was sent to the Camden County Youth Detention Center was involved in at least 26 separate critical incidents in the facility. He threatened to commit suicide numerous times, and

attempted suicide at least five times. He repeatedly exhibited symptomatic behavior, such as urinating on the floor and showering with his clothes on, in spite of being corrected or reprimanded after each incident. He tried to escape twice by running around the facility unattended. He pulled the fire alarm twice within one hour, and when questioned why he did so, the resident reportedly responded that he is "messed up in the head and can't remember things." One afternoon, while the resident was in isolation, ranting about not wanting a white person to bring his dinner tray, he complained aloud that he feared white people would spit in it, and stated that he would kill them if they did. He then asked a social worker to take him off suicide watch. She agreed to do so if he promised to behave, but he responded by threatening to beat her up. Later that evening while in confined isolation, he was found scratching himself with a piece of putty, which he threatened to swallow. Later still that night, he was observed in isolation with a piece of elastic from his underwear tied around his neck, attempting to hang himself from a light fixture.

- In April 2004, a resident at the juvenile detention center in Union County tried to commit suicide by drinking the chemicals from an ice pack. He was sent for evaluation for a possible placement in a psychiatric unit after being treated. In May 2004, while still detained, it was reported that he was on two different psychotropic medications, and he displayed suicidal behavior on at least four separate occasions. He once threatened to kill himself after a lockdown, resulting in a Juvenile Detention Officer ("JDO") removing the sheets from his room. On another occasion, he was observed with something around his neck, which was eventually found to be a noose made out of paper. Ten days after that incident, he was found in his room cutting his wrist with a sharp, broken plastic cup while covering the window to his room with a shirt. When the cup was taken away, he threatened to hang himself. The following day, this resident was observed with new scratches on his arms. He was found less than two weeks later in his room with a screw in his mouth. Staff members tried to convince him to take the screw out of his mouth, but he swallowed it, and was taken to the hospital. While in detention, the juvenile was also charged with physically assaulting three staff members.

- In May 2004, a 16-year-old youth was admitted to the Passaic County Juvenile Detention Center from a group home. He was transferred to the detention center due to aggressive and inappropriate sexual behavior toward staff at the group home. By mid-September, he had attempted suicide at least 14 times and made numerous suicidal threats. On one occasion, this resident refused to return to his room after assaulting another detainee. He was escorted to his room, where he tied a sheet around his neck. The sheet was removed, and the resident then ripped his jumper and attempted to tie it around his neck. At this point, he was handcuffed, but still managed to rip his t-shirt and try to tie it around his neck while he was restrained. He also displayed symptomatic behavior on several occasions by destroying mattresses so that he could make figurines out of the foam inside them. This

resident was on at least two psychotropic medications when he entered the facility, and was maintained on medication while detained. He admitted during an evaluation that his mother was deceased, and he wished he was as well.

Juvenile detention centers now serve inappropriately and illegally as placements to confine youth awaiting appropriate placement and treatment through DYFS and DCBHS. These county institutions are not designed to serve this population and they provide grossly inadequate mental and behavioral health care. The prolonged detention of these youth is symptomatic of an acute shortage of residential and community mental health services and treatment options for youth, and points to the urgent need to grow that capacity and strengthen the coordination among State agencies, county agencies, and the courts.

(3) Mental health screening and assessment within youth detention centers are inadequate.

Although thousands of youth in New Jersey's county juvenile detention centers evidence serious mental health disorders each year, very little is done in most detention centers to identify these youth and to measure the extent of their needs. Confinement exacerbates serious mental health disorder, but in most instances county detention centers are ill-equipped to discern and meet the mental and behavioral health needs of all admitted youth. Failure to identify youth in need of services is dangerous for staff and youth alike.

Our investigation revealed only rudimentary activity with respect to mental health screening in most detention facilities. Present screening practice centers primarily on administering a basic suicide risk instrument during a youth's admission to detention. In the vast majority of detention centers, Juvenile Detention Officers ("JDOs") administer these screens. While it is mandatory and essential that suicide screening be conducted, suicide screens are insufficient to identify other crucial indicators of mental health disorders. In addition to a suicide risk screening, a separate and comprehensive screen is also necessary to detect other immediate needs or concerns a youth may have. We believe the use of an evidence-based, comprehensive screening tool is necessary to properly manage youth in detention who have serious mental health needs.

We further found that full mental health assessments are not regularly conducted for youth in county detention centers, placing youth and staff alike at great risk of harm. Despite the presence of youth with serious mental health disorders in detention, fewer than half of the counties' detention centers regularly employ additional instruments or take further measures to assess mental health or substance abuse problems. County detention centers vary widely in when and how they conduct mental health assessments. Some counties conduct full mental health assessments on all youth admitted to their facilities, others conduct such assessments only when court ordered to do so, or upon indication or observation of acute need.

(4) Mental health care within youth detention centers is grossly inadequate.

Detention is intended to be a short-term setting for youth awaiting more appropriate placements or commitment to the JJC. Historically, social services within facilities have been designed to serve short-term needs. But the presence of children with significant mental and behavioral health needs in detention presents the urgent need for more appropriate mental health and child welfare alternatives, which DHS promises to have in place by July 2005. Until those services are operational and sufficient, the unmet need for comprehensive and substantive mental health services for youth in detention looms large. Because a significant percentage of these youth remain in detention for extended periods of time, it is imperative that specialized and continued care is provided as a short-term but critical service.

The level of available care and access to that care are both limited in detention centers. Mental health clinical services are highly inconsistent among counties. Only nine of 17 detention centers indicated that they had access to Master's degree level clinicians or higher. Seven of these nine detention centers reported that they employed licensed Master's degree level clinicians, and four of those nine counties indicated the presence of Ph.D. level clinicians on staff. Nine counties reported that staff mental health clinicians were certified drug and alcohol counselors. In addition, the type of service available varies from only assessment services or one time crisis services to weekly individual counseling.

When such vulnerable youth are held in a secure, non-therapeutic environment and do not receive adequate, ongoing mental health care, the damage to that youth's psychological functioning can be immense. Failure to meet these needs is analogous to housing a youth suffering from asthma in conditions known to cause serious respiratory distress without providing treatment to prevent serious attack. By failing to address youth's identified mental health needs, facilities are left to manage youth whose mental state is worsening, sometimes to the point of serious harm to themselves or others.

(5) Many detained youth are improperly denied Medicaid coverage.

Youth in detention awaiting non-secure placements are entitled to Medicaid coverage, but do not now receive it because of an overly broad exclusion in State regulations. In addition, the state does not presently fund medical services in detention for all youth through the State Medicaid program, though it could and should. The result would be better quality service provision, more uniform systems of care, additional programming, and an up-tick in federal investments of approximately $600,000 annually in the health delivery system for youth.

RECOMMENDATIONS

Thousands of youth with serious emotional disturbance in county detention centers are grossly ill-served by a system that fails them in every significant respect. To that end, we make the following recommendations to decrease the time youth experiencing serious mental health disorders stay in county detention centers and to improve the services they receive while in these facilities. Our recommendations are directed to the two primary State agencies responsible for regulating the care of and providing services to this population, the JJC and the DHS, and to counties that operate youth detention centers. While these recommendations specify particular actions needed to remediate the current shortcomings in the system, among the most important steps to reforming the system is better coordination among all the key entities involved in the lives of these young people.

Juvenile Justice Commission:

The report demonstrates the need for revision of the Manual of Standards. In particular, the Manual should have more detailed provisions on the evaluation of serious mental health disorder and provision of service to those youth in greatest need. The report also highlights the importance of the JJC exercising its regulatory oversight responsibility as mandated by statute. To that end, the OCA makes the following recommendations:

1. The JJC should immediately enforce N.J.A.C. 13:92-5.2, which forbids the detention of youth in any detention center that has a population exceeding its maximum rated capacity.
2. In order to provide more tools for enforcing regulations than simply restricting new admissions to a detention center, the Executive Board of the JJC should amend its regulations to provide for a graduated system of intermediate sanctions for violations of the Manual of Standards, including, but not limited to:
    - heightened reporting requirements;
    - fines for non-compliance that places children at risk of harm;
    - capacity to authorize an independent entity, or the JJC itself, to take over the management of a non-compliant facility.
    - policy to make public, and post to its web site, all monitoring reports of the county detention centers, including all required corrective actions or imposed penalties.
3. The JJC should every week update and make public, and post to its web site, both the rated census capacity and the average weekly population for every county detention center.
4. The Manual of Standards should be amended to require that every juvenile detention center have a licensed mental health clinician (Psychologist or Licensed Clinical Social Worker) with responsibility for mental health care services pursuant to a written agreement, contract or job description. That

clinician should meet with the facility administrator at least once every six months to review policies and procedures for provision of mental health services. The clinician should ensure:

   a. Every youth entering the facility receives an evidenced-based screening by a trained staff member within 12 hours;
   b. Every youth residing in the facility receives an evidence-based mental health assessment by a trained, qualified staff member within seven days of entering the facility;
   c. That ongoing mental health care services are provided to youth who demonstrate need at the screening or assessment;
   d. That psychiatric services are available to youth in the facility on an emergency or crisis basis; and,
   e. That medication is properly distributed and prescribed to youth in the facility in accordance with professional standards.

5. The Manual of Standards should be amended to require that all newly admitted youth be placed on an elevated self-harm watch for the first 48-hours in detention, with attendant proscription that such supervision not include isolation of the youth.
6. The Manual of Standards should be amended to require that all suicide threats and attempts by children in county detention centers be immediately reported to the JJC.
7. The JJC, which has recently expanded the number of Police Training Commission classes, should immediately enforce the requirement that all Juvenile Detention Officers complete Police Training Commission-authorized training within one year of being hired.
8. The JJC should work with the Police Training Commission and consult with experts in the field of juvenile justice and mental health to develop a comprehensive training curriculum for Juvenile Detention Officers and youth workers focusing on the mental health needs of the juvenile detention population, in addition to its existing suicidality curriculum.
9. At present, the JJC is allotted 30 days to complete the process of moving a juvenile from detention to commitment placement. The regulation should be rewritten to call for more expedient transfer from detention to commitment.

Department of Human Services:

The DHS plays a crucial role in making available greater services to youth and in streamlining the process for youth to access those services. In this regard, the Child Welfare Reform Plan is a significant step toward addressing some of the problems addressed in this report. That said, there is no greater priority than moving children out of restrictive jail-like settings if they do not belong there. And hundreds of children in detention today do not. Making children wait in detention for mental and behavioral health services or placements is not responsible, humane or just. Existing resources within the Child Welfare Reform Plan must be prioritized to serve children most in need, and illegally institutionalized and detained children are among those whose need is most exigent. We make the following recommendations:

1. As proposed by the Plan, DHS must create adequate resources for community-based services to free children waiting for DHS services or placements from behind bars. The OCA here again supports DHS's various strategies within the Plan, but the most critical benchmark is the DHS pledge to free children waiting in detention for a DHS placement by July 2005, and never again allow a child to languish there. DHS must ensure it has in place a strategy and implementation plan to achieve those promises. OCA will monitor DHS's progress in achieving this goal in part by conducting a statewide audit of all detention centers in July 2005.
2. DHS should assign clinical staff to every county detention center as quickly as possible, and no later than February 1, 2005, to perform assessments for all youth and make case planning determinations, so as to provide the fastest possible movement of youth out of detention and into placements and to identify youth appropriate for less restrictive environments and remove them from detention. This program has been effective in moving youth out of detention more quickly in Camden County and should be expanded statewide. We recommend, as with all provisions of the Plan that require DHS to respond to the needs of detained youth, that the DHS prioritize youth in detention centers that have experienced crowding in the last 18 months.
3. DHS should collect data weekly on the number of detained children awaiting a DHS placement in every county detention center, and make public, including posting to its website, the weekly count for every county detention center.
4. DHS should reimburse the counties for the cost of housing and serving youth who have been ordered into the custody of DHS, but who remain in detention for more than one week after such an order.
5. DHS should provide for counseling or other appropriate services for youth who have been ordered into its custody, but who remain in the detention center for more than one week after such an order.

New Jersey Division of Medical Assistance and Health Services, within DHS:

There are a number of steps that New Jersey could and should take to ensure that youth in, and released from, detention facilities receive the Medicaid coverage to which they are entitled. These include the following:

Provide Medicaid coverage to all detained youth, including those in detention prior to disposition;

1. Auto-enroll detained children into Medicaid upon admission to detention.
2. Collect and record Medicaid eligibility and coverage data for youth in the juvenile justice system.
3. Alter the State's Medicaid regulations so that youth entering detention facilities remain eligible for Medicaid while in detention. Issue an all county letter to inform detention facilities of this change.

4. Issue an all county letter confirming that all youth with a placement order for a non-secure setting (such as home or DYFS) are entitled to Medicaid services, if they are otherwise eligible.
5. Create Medicaid "look alike" numbers for all Medicaid eligible youth in detention so that their bills can be sent to Medicaid and payers can pay the lower Medicaid rate for expenses.
6. Develop a process at detention facilities for all youth to complete the Medicaid application/reactivation process prior to release.

Union County:

Consistent with OCA's findings in Appendix A of this report, the George W. Herlich Juvenile Detention Center, commonly referred to as the Union County Juvenile Detention Center, which is located on the top level of a parking garage in Elizabeth, New Jersey, is a substandard and unacceptable facility. The County reports that it intends to construct a new detention center for children, which OCA supports and expects. OCA strongly recommends the County take immediate, significant and affirmative steps to launch its proposed construction project within the next sixty days. OCA intends to monitor the county's progress carefully and to take other steps as necessary and available by statute if significant progress is not forthcoming.

***Multi-Agency Recommendations*:**

1. DHS and the JJC should immediately remove all youth in detention post-disposition awaiting placement in non-secure facilities and place them in less restrictive, more appropriate environments.
2. County officials should immediately create and enact overflow plans to stop the illegal placement of juveniles in facilities that have exceeded rated capacity. To comply with section 2A:4A-37c of the Juvenile Code, which prohibits the placement of any juvenile in a detention center that is beyond capacity, the overflow plans must be designed to trigger any time a facility nears or reaches its rated capacity.
3. Counties should bill DHS for the cost of housing and serving youth who have been ordered into the custody of DHS, but who remain in detention for more than one week after such an order.
4. County officials, JJC and DHS should create a unified system for coordinating services, both inside and outside of juvenile detention centers to ensure that youth's needs are met. They also should ensure that the cost of implementing these added services are properly allocated among the responsible entities. To that end, the DHS and JJC must ensure that county-level coordination and tracking of youth is created and provide county officials with necessary training and protocols on accessing services or support. County officials must use the trainings and protocols to make State actors aware of youth in need of services or placement.